Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CMH Occupational Health

Respondent Name
EMCASCO Insurance Co

MFDR Tracking Number
M4-14-0931-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…for determination of treating physician."

Amount in Dispute: $441.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the Requester's failure to request reconsideration, failure to timely submit his request for medical fee dispute resolution within one year and the arguments set forth above, the carrier asks that the Requester's request for reimbursement be denied."

Response Submitted by: The Silvera Firm, 1015 Providence Towers East, 3001 Spring Valley Road, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2012 – December 6, 2012	99213, 99080	$441.00	$65.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 38 – Services not provided or authorized by designated providers

Issues

1. Did the respondent raise a new denial or defense?
2. Did the requestor waive the right to medical fee dispute resolution?
3. What is the applicable fee guideline?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent states, “The use of CPT code 99213, is inappropriate.” 28 Texas Labor Code §133.307(d)(2)(F) states in pertinent part, “The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…” Therefore the disputed services will be reviewed per denial reasons provided at the time the claim was initially adjudicated and reconsidered.
2. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is July 2, 2012 through November 16, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 20, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division’s MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.
3. 28 Texas Administrative Code §134.203(c) states, “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).
    - Procedure code 99213, service date December 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.97. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 0.912 is 1.0032. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.809 is 0.05663. The sum of 2.02983 is multiplied by the Division conversion factor of $55.30 for a MAR of $112.25. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $65.00.
4. The total allowable reimbursement for the services in dispute is $65.00. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $65.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $65.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $65.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November ,2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.